STATE OF MICHIGAN

DEPARTMENT OF CONSUMER & INDUSTRY SERVICES

OFFICE OF FINANCIAL AND INSURANCE SERVICES

Before the Commissioner of Financial and Insurance Services

In the matter of

XXXXX
Petitioner **File No. 86877-001**

v

Health Alliance Plan of Michigan
Respondent
_____/

Issued and entered
This 1st day of February 2008
by Ken Ross
Acting Commissioner

ORDER

I
PROCEDURAL BACKGROUND

On December 28, 2007, XXXXX, authorized representative of XXXXX (Petitioner), filed a request for external review with the Commissioner of Financial and Insurance Services (Commissioner) under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq*. On January 8, 2008, after a preliminary review of the material submitted, the Commissioner accepted the request.

The issue in this matter can be decided by analyzing the Health Alliance Plan of Michigan (HAP) subscriber contract (the contract) which defines the Petitioner's health care coverage, along with Rider 251 (the rider) which added prescription drugs to her basic coverage. The Commissioner reviews contractual issues under MCL 500.1911(7). No medical issues are presented requiring analysis by an independent medical review organization.

II
FACTUAL BACKGROUND

The Petitioner is a member of Health Alliance Plan (HAP). HAP requires a $20.00 copayment for each prescription or refill of a preferred brand drug. The Petitioner requested a 90-day supply of compounded progesterone cream. HAP approved coverage for a 90-day supply but applied three copayments for a total of $60.00 ($20.00 for each 30-day supply).

The Petitioner initially paid $60.00 for the 90-day supply and then appealed, asking HAP to cover the 90-day supply for a single copayment of only $20.00 and reimburse her $40.00. HAP denied the request, saying it applied the copayment in accordance with the rider.

The Petitioner exhausted HAP's internal grievance process and received its final adverse determination letter dated November 2, 2007.

III
ISSUE

Did HAP properly deny the Petitioner's request for a 90-day supply of compounded progesterone cream for a copayment of only $20.00?

IV
ANALYSIS

Petitioner's Argument

The Petitioner says HAP's application of a $20.00 copayment for each 30-day supply of her prescription is arbitrary and has no basis in the rider. She says that the rider specifically provides for a copayment of $20.00 "for each prescription." While the rider says "HAP may impose quantity restrictions…to insure quality, safety and cost-effective drug use," she does not think that provides a basis for in effect changing her 90-day prescription into three 30-day prescriptions.

The Petitioner argues that a 90-day supply is cost effective because it will not require multiple preparations and therefore there should be no need for the multiple copayments. She believes only one $20.00 copayment is warranted for a 90-day supply.

HAP's Argument

In its final adverse determination letter, HAP denied coverage for a 90-day supply of progesterone cream with only a $20.00 copayment saying:

> HAP may impose quantity restrictions, prior authorization requirements, and exclusions on outpatient prescription drugs to assure quality, safety and cost effective drug use consistent with HAP benefit referral and practice policies.

Following the Petitioner's grievance, HAP says it made an exception and approved the Petitioner's request to get a 90-day supply of the progesterone cream (instead of just a 30-day supply) but it said each 30-day supply would still require the $20.00 copayment for preferred and brand name drugs.

HAP believes its denial of a 90-day supply for only one $20.00 copayment is appropriate under the terms of the contract and the rider.

Commissioner's Review

The issue is whether HAP properly denied coverage for a 90-day supply with only one $20.00 copayment.

The Petitioner's original contract did not include coverage for outpatient prescription drugs. According to HAP, in 2007 the Petitioner's former employer purchased a two-tier prescription drug plan (Rider 251) that imposed an $8.00 copayment for generic drugs and a $20.00 copayment for preferred brand drugs.[1] The rider amended the contract by adding outpatient prescription drugs to the "Services and Benefits" section with this language:

[1] The record is not clear when the rider went into effect but the Petitioner does not challenge the validity of the rider as it applies to the prescription in question here.

Outpatient Prescription Drugs

> All outpatient prescription drugs approved by the Food and Drug Administration unless excluded.
>
> HAP may impose quantity restrictions, prior authorization requirements, and exclusions on outpatient prescription drugs to assure quality, safety and cost-effective drug use consistent with HAP benefit, referral and practice policies. [Underlining added]

The rider also amended the "Exclusions and Limitations" section of the contract by adding new language on page 15 in place of the language in Section 5.1(o). That section now reads:

> **The following are not covered under this Contract:**
>
> * * *
>
> (o) **Outpatient Prescription Drugs**
>
> * * *
>
> 8. Greater than 35-day supply and/or restricted coverage.
> 9. Outpatient prescription drugs on HAP's maintenance drug list, as determined by HAP or its designee, may be limited to a 35-day supply or 100-dose unit, whichever is greater.

The rider permits HAP to impose quantity restrictions on outpatient prescription drugs (including maintenance drugs) and in this instance HAP has chosen to exclude coverage for any fills of progesterone cream in excess of a 35-day supply. Therefore, since HAP could require a separate refill for every 35-day supply, it may apply the $20.00 copayment to each 35-day supply even though it has permitted the Petitioner in this case to receive a 90-day supply at one time.

The Commissioner finds that HAP's application of a $60.00 copayment for a 90-day supply of progesterone cream is consistent with the contract and the rider.

V
ORDER

The Commissioner upholds HAP's November 2, 2007 final adverse determination. HAP properly applied a $20.00 copayment for each 30 day refill.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than sixty days from the date of this Order in the Circuit Court for the county where the covered person resides or in the Circuit Court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of the Office of Financial and Insurance Services, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.